

## 2007 Medical Plan Comparison PNNL Salaried Staff and Interns

Levels of Coverage:

Employee Only  
Employee & Spouse/Registered Domestic Partner

Tier I  
Tier II

R&C = Reasonable and Customary

Employee & Children  
Employee, Spouse/Registered Domestic Partner, & Children

Tier III  
Tier IV

Plan Name	Network Status	Deductible			Covered Expenses		Annual Out-of-Pocket Maximums (includes Deductible)		
		Tier I	Tier II & III	Tier IV	Plan Pays	You Pay	Tier I	Tier II & III	Tier IV
<b>Anthem Blue Cross/Blue Shield Plan</b>	<b>In-Network</b>	None			100% After Copay	Varies	\$1,000 / \$2,000 (includes copays)		
	<b>Out-of-Network</b>	N/A			N/A	N/A	N/A		
<b>Premiera Blue Cross/Blue Shield Plan</b>	<b>In-Network</b>	\$250	\$250 per person \$500 per family		80% After Copay	\$20 Office Visit \$100 Hospital then 20%	\$2,250	\$2,250 per person \$5,500 per family	
	<b>Out-of-Network</b>				60% R&C	40% plus costs over R&C			

Lifetime Maximum	
<b>Anthem Blue Cross/Blue Shield Plan</b>	\$2,000,000 per covered individual
<b>Premiera Blue Cross/Blue Shield Plan</b>	\$2,000,000 per covered individual

As indicated above, the Plans pay a percentage of allowable or reasonable and customary charges (R&C)\* after your covered expenses reach the individual or family deductible. The out-of-pocket maximum does not apply to charges in excess of allowable or R&C, Mental Illness or Substance Abuse expenses. The out-of-pocket maximum also does not apply to mail order drug purchases, copays and differentials for brand drug purchases at retail where a generic is available. You are always responsible for your share of the coinsurance and copayments for these expenses. The participant is not responsible for charges by in-network providers over and above the contracted allowable changes.

**This benefit description is intended to be a brief outline of coverage and is not intended to be a legal contract. Benefits are described more fully in the plan document, which is available for review at the Battelle office that administers this Plan for you. In the event of a conflict between the plan document and the description provided herein, the terms of the plan document will prevail. This material is for informational purposes only and it is not intended to serve as a legal interpretation of benefits. Reasonable effort is made to have this material represent the intent of the Plan language. However, the plan document stands alone and is not considered as supplemented or amended in any way by the explanations or examples included in this material.**

Benefits under the Anthem Blue Cross/Blue Shield and Premiera Blue Cross/Blue Shield Plans will be paid only if the Plan Administrator (or its delegate) in its discretion decides that the applicant is entitled to them.

Description of Medical Plan Coverage	Anthem Blue Cross/Blue Shield Plan		Premera Blue Cross/Blue Shield Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Ambulance</b> Charges for professional ambulance services to or from the nearest hospital.	Covered in full for in-network providers. Covered in full for out-of-network providers for emergency only.	Not covered.	\$75 copay then covered at 80% after deductible for emergency only.	\$75 copay then covered at 80% of R&C after deductible for emergency only.
<b>Dental Surgery (Accident Only)</b> Charges for dental work necessitated by accidental injury to natural healthy teeth while covered under this Plan.	Covered in full after ER or office visit copay for initial treatment for damage to sound, natural teeth resulting from accidental injury that happens while covered by this Plan.  Copay amount dependent on place of service.	Not covered.	Covered at 80% after deductible.	Covered at 80% of R&C after deductible.
<b>Durable Medical Equipment (DME)</b> Charges for rental or purchase of durable medical equipment (DME).	Covered in full.	Not covered.	Covered at 80% after deductible.  Medical Equipment / Prosthetics / Medical Supplies combined annual limit of \$10,000.	Covered at 60% of R&C after deductible.  Medical Equipment / Prosthetics / Medical Supplies combined annual limit of \$10,000.
<b>Education and Training</b> Charges in connection with custodial care, education or training, including orthoptic or vision training.	Not covered.	Not covered.	Covered at 100% per calendar year to a maximum of \$250 per calendar year.	Not covered.
<b>Emergency Care Health Services</b> Emergency care, including Hospital Emergency Room, Alternate Facility, or Urgent Care Center.	<u>Emergency room</u> covered in full after \$75 copay for treatment of life-threatening emergency. Copay waived if admitted. 24-hour notification required following treatment.  <u>Urgent Care Center</u> : Covered in full after \$25 copay.	<u>Emergency room</u> covered in full after \$75 copay for treatment of life-threatening emergency. Copay waived if admitted. 24-hour notification required following treatment.  <u>Urgent Care Center</u> : Not covered	\$75 copay for treatment of life-threatening emergency. Copay waived if admitted. Then covered at 80% after deductible.  <u>Urgent Care Center</u> : Covered in full after \$25 copay.	\$75 copay for treatment of life-threatening emergency. Copay waived if admitted. Then covered at 60% after deductible.  <u>Urgent Care Center</u> : Covered at 60% after deductible.
<b>Eye Examination</b> Eye exams received from a health care provider in the provider's office.	Covered after \$20 copay. Limited to one examination per member per calendar year.	Not covered.	\$20 copay per visit  Limited to one examination per member per calendar year.	Covered at 60% of R&C after deductible.  Limited to one examination per member per calendar year.

Description of Medical Plan Coverage	Anthem Blue Cross/Blue Shield Plan		Premera Blue Cross/Blue Shield Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Hospital – Inpatient</b> Charges for hospital bed and board, limited to the hospital's most common semi-private daily rate. See "Mental Illness/Substance Abuse" for other limitations.	Covered in full after \$100 copay per admission – unlimited days in semi-private room.	Not covered.	\$100 copay per admission then covered at 80% after deductible.	\$100 copay per admission then covered at 60% of R&C after deductible.
<b>Hospital – Outpatient</b> Charges by a hospital for medical care and treatment on an outpatient basis. See "Mental Illness/Substance Abuse" for other limitations.	Covered in full after \$50 copay for outpatient surgery.  All other outpatient services covered in full.	Not covered.	\$100 copay per admission then covered at 80% after deductible.	\$100 copay per admission then covered at 60% after deductible.
<b>Hospital – Preadmission Testing</b> Charges for preadmission testing prior to hospital confinement.	Covered in full.	Not covered.	See hospital benefits.	
<b>Infertility Services</b> Covers diagnosis and treatment of infertility.	Office visits and tests are covered in full after \$20 copay up to diagnosis.  Covers diagnosis only.	Not covered.	Not covered.	
<b>Injections (Therapeutic)</b> Charges for injections received in a Physician's office when no other health service is received (i.e., allergy shots).	Allergy injections and/or serum covered in full. If office visit is rendered, \$20 office copay may be charged.  Routine immunizations and inoculations covered in full after \$20 copay.	Not covered.	Covered at 80% after deductible.  Physicians Services copay may apply.  <i>For immunizations, see Preventive Care.</i>	Covered at 60% of R&C after deductible.  Physicians Services copay may apply.  <i>For immunizations, see Preventive Care.</i>
<b>Laboratory Services / X-rays</b> Diagnostic x-rays and laboratory services; x-ray, radium and radioactive isotope treatment; oxygen and other gases and administration thereof; blood transfusions and blood not donated or replaced; anesthesia and its administration.	X-ray and laboratory tests covered in full in physician's office after \$20 copay.  Tests at medical facilities covered in full.	Not covered.	Covered at 80% after deductible.  Physicians Services copay may apply.  Benefit includes both diagnostic and screening mammograms and colon screenings.	Covered at 60% of R&C after deductible.  Physicians Services copay may apply.  Benefit includes both diagnostic and screening mammograms and colon screenings.

Description of Medical Plan Coverage	Anthem Blue Cross/Blue Shield Plan		Premera Blue Cross/Blue Shield Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Maternity Benefit</b> Charges for pregnancy expenses for covered individuals only. Coverage for pregnancy ceases when Plan coverage terminates.	First pre-natal visit is subject to \$20 office copay. Professional fees covered in full after initial visit.  Hospital and delivery covered in full after \$100 copay.  Dependent children are covered.  <i>Note: if newborn stays in Hospital beyond the Mother's stay, the newborn becomes own entity. Staff must enroll newborn to plan within 31 days of birth.</i>	Not covered.	\$20 copay for initial visit.  See Hospital Inpatient and Laboratory Services / X-rays for coverage of other expenses.  Dependent children not covered.  <i>Note: Staff must enroll newborns in plan within 31 days beginning on the date of birth.</i>	Initial visit covered at 60% of R&C after deductible.  See Hospital Inpatient and Laboratory Services / X-rays for coverage of other expenses.  Dependent children not covered.  <i>Note: Staff must enroll newborns in plan within 31 days beginning on the date of birth.</i>
<b>Mental Illness/Substance Abuse (MH/SA)</b> Charges for R&C expenses rendered in a physicians office or other appropriate facility, incurred because of mental health or substance abuse. Subject to coordination of care prior to inpatient admission.	<b>Inpatient:</b> Covered in full after \$100 copay per admission up to 30 days per calendar year.  <b>Outpatient:</b> Covered in full after \$20 copay per visit, up to 50 visits per calendar year.  Inpatient and outpatient substance abuse programs limited to two per lifetime.  <i>Visit limits are not combined between MH and SA.</i>	Not covered.	<b>Mental Illness</b> <b>Inpatient:</b> \$100 copay per admission then covered at 80% after deductible to a maximum of 20 days per year.  <b>Outpatient:</b> \$25 copay per visit to a maximum of 30 visits per year.	<b>Mental Illness</b> <b>Inpatient:</b> Covered at 60% of R&C after deductible to a maximum of 20 days per year.  <b>Outpatient:</b> Covered at 60% of R&C after deductible to a maximum of 30 visits per year.
			<b>Substance Abuse</b> <b>Inpatient:</b> \$100 copay per admission then covered at 80% after deductible to a maximum benefit of \$13,500 in any rolling 24-month period.  <b>Outpatient:</b> \$15 copay then 80% after deductible to a maximum benefit of \$13,500 in any rolling 24-month period.	<b>Substance Abuse</b> <b>Inpatient:</b> \$100 copay per admission then covered at 60% after deductible to a maximum benefit of \$13,500 in any rolling 24-month period.  <b>Outpatient:</b> \$15 copay then 60% after deductible to a maximum benefit of \$13,500 in any rolling 24-month period.
<b>Nutritional Counseling</b> Covered health services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet.	Diabetic education and certain medical nutritional therapy covered in full after \$20 copay.	Not covered.	\$20 copay per visit.  Nutritional therapy for conditions other than diabetes is limited to 4 visits per member per calendar year. Nutritional therapy for the condition of diabetes isn't subject to a maximum benefit.	Covered at 60% of R&C after deductible.  Nutritional therapy for conditions other than diabetes is limited to 4 visits per member per calendar year. Nutritional therapy for the condition of diabetes isn't subject to a maximum benefit.

Description of Medical Plan Coverage	Anthem Blue Cross/Blue Shield Plan		Premera Blue Cross/Blue Shield Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Physician Services</b> Charges for professional services of physicians (unless practitioner is a family member).	Covered in full after \$20 copay per visit. No referral from Primary Care Physician required to see a specialist. Naturopaths not covered. Allergy Testing covered in full.	Not covered.	\$20 copay per visit.	Covered at 60% of R&C after deductible.
<b>Prescription Drugs</b> Drugs and medicines requiring a physician's (or dentist's) prescription for a specific illness and dispensed by a pharmacist.	<u><b>Retail</b> (30-day supply)</u> <ul style="list-style-type: none"> <li>Generic: \$15 copay</li> <li>Preferred: \$30 copay</li> <li>Non-Preferred: \$40 copay</li> </ul> <b>Mail Order offered through APM</b> <u><b>Mail Order</b> (90-day supply)</u> <ul style="list-style-type: none"> <li>Generic: \$20 copay</li> <li>Preferred: \$60 copay</li> <li>Non-Preferred: \$80 copay</li> </ul> Benefits are not available for all drugs. Some benefit limitations and prior authorization may apply for certain prescription benefits. <i><b>For Retail and Mail Order:</b> If you elect a brand name drug when a generic is available, you will be responsible for both your copay and the price difference between the brand name and the generic drug.</i> <b>Maintenance Medications:</b> Medications taken on a routine basis must be ordered through <b>Mail Order</b> . However, when first starting the medication you are permitted to use <b>Retail</b> for the initial 30 day prescription and two 30 day refills.	Not covered.	<u><b>Retail</b> (30-day supply)</u> <ul style="list-style-type: none"> <li>Generic: \$15 copay</li> <li>Preferred: \$30 copay</li> <li>Non-Preferred: \$40 copay</li> </ul> <b>Mail Order offered through Medco</b> <u><b>Mail Order</b> (90-day supply)</u> <ul style="list-style-type: none"> <li>Generic: \$20 copay</li> <li>Preferred: \$60 copay</li> <li>Non-Preferred: \$80 copay</li> </ul> Benefits are not available for all drugs. Some benefit limitations and prior authorization may apply for certain prescription benefits. <i><b>For Retail and Mail Order:</b> If you elect a brand name drug when a generic is available, you will be responsible for both your copay and the price difference between the brand name and the generic drug.</i>	<u><b>Retail</b> (30-day supply)</u> <ul style="list-style-type: none"> <li>Generic: \$15 copay then 60%</li> <li>Preferred: \$30 copay then 60%</li> <li>Non-Preferred: \$40 copay then 60%</li> </ul>

Description of Medical Plan Coverage	Anthem Blue Cross/Blue Shield Plan		Premera Blue Cross/Blue Shield Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Preventive Care</b> Routine physical examinations including <ul style="list-style-type: none"> <li>Hearing screenings</li> <li>Pap smears and pelvic exams once per calendar year unless deemed necessary by your provider,</li> <li>Well-woman, well-man, newborn, well-baby and well-child services</li> </ul>	Covered in full after \$20 copay  Hearing examination \$20 copay, limited to one examination per member per year.  Cost of Hearing Aid not covered. (Discounts available – see “Special Offers” section on Anthem website.)  Includes annual mammogram and colonoscopy and sigmoidoscopy once every 5 years after age 50  No annual maximum.	Not covered.	\$20 copay per visit  Pap smear, screening mammogram, colonoscopy and sigmoidoscopy are covered under the Laboratory Services and X-rays benefit.  Covered in full to a maximum of \$500 per person per calendar year not including diagnostic and screening lab services and x-rays	Not covered.
<b>Rehabilitation Services – Outpatient Therapy</b> Charges for the following therapies: physical, occupational, speech, pulmonary rehabilitation, cardiac rehabilitation.	Covered in full after \$20 office copay. Covered in full for outpatient facility. <i>Massage therapy is <u>not</u> a covered benefit.</i>  <u>Annual Therapy Limits:</u> Physical – 30 visits per member Occupational – 30 visits per member Speech – 20 visits per member	Not covered.	\$20 copay per office visit to an annual maximum benefit of 45 visits for all therapies combined.  <i>This benefit includes massage therapy – written physician referral required.</i>	Covered at 60% of R&C after deductible to an annual maximum benefit of 45 visits for all therapies combined.  <i>This benefit includes massage therapy – written physician referral required.</i>
<b>Skilled Nursing Facility</b> Charges by a qualified special care facility for medical care and treatment, with charges for accommodations not in excess of the rate of the facility’s most common rate for semiprivate accommodations.	Covered in full after \$100 copay.  Subject to coordination prior to admission.	Not covered.	\$100 copay per admission then covered at 80% after deductible to an annual maximum benefit of 90 inpatient days per calendar year if admitted within 14 days of hospitalization.	Covered at 60% of R&C after deductible to an annual maximum benefit of 90 inpatient days per calendar year if admitted within 14 days of hospitalization.

Description of Medical Plan Coverage	Anthem Blue Cross/Blue Shield Plan		Premera Blue Cross/Blue Shield Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy</b>  Benefits available when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services.	Covered in full after \$20 copay.  Spinal manipulation coverage up to a maximum of 12 visits per year per member.  Acupuncture is not a covered benefit.	Not covered.	\$20 copay per visit.  <ul style="list-style-type: none"> <li>Acupuncture covered to a maximum benefit of 24 visits per year.</li> <li>Chiropractic covered a maximum benefit of 24 visits per year.</li> </ul>	Covered at 60% of R&C after deductible.  <ul style="list-style-type: none"> <li>Acupuncture covered to a maximum benefit of 24 visits per year.</li> <li>Chiropractic covered a maximum benefit of 24 visits per year.</li> </ul>
<b>Transplant Services</b>  Charges for certain organ and tissue transplants when ordered by a physician.	Covered in full for bone marrow, heart, heart/lung, liver, pancreas, or Kidney/pancreas transplant services received at Blue Quality Centers for Excellence. Kidney and cornea transplant services paid as any other service under medical.  Transplantation services must be received at a designated Blue Quality Centers for Excellence in the United States to be covered.  Subject to coordination of care prior to admission.	Covered at 50%.	Covered as any other condition to a maximum benefit of \$250,000.  Subject to coordination of care prior to admission.	Prior approval needed.
<b>Vision - Hardware</b>  Charges for eyeglasses, contact lenses, examinations for prescription eyeglasses or contact lenses.  <i>See Eye Examinations</i>	\$150 maximum allowance during rolling 24 month period  <i>See Eye Examinations.</i>	Not covered.	Frames, lenses, and contacts covered at 100%, up to a maximum benefit of \$150 during rolling 24-month period.	Frames, lenses, and contacts covered at 100%, up to a maximum benefit of \$150 during rolling 24-month period..

## MANDATED MEDICAL BENEFITS

Description of Medical Plan Coverage	Anthem Blue Cross/Blue Shield Plan		Premera Blue Cross/Blue Shield Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<p><b>Mandated Health Benefits</b></p> <p>Federal law requires group health plans to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy if agreed to by the patient and attending physician:</p> <ul style="list-style-type: none"> <li>• Reconstruction for the breast on which the mastectomy was performed.</li> <li>• Surgery or reconstruction of the other breast to produce a symmetrical appearance.</li> <li>• Prostheses, and</li> <li>• Physical complications for all stages of a mastectomy, including swelling associated with the removal of lymph nodes.</li> </ul> <p>This coverage would be made available to participants or beneficiaries who are receiving benefits in conjunction with a mastectomy and who elect breast reconstruction.</p>	Covered. Copays and coinsurance for related services may apply and are subject to provisions consistent with other benefits under the Plan.	Covered as required by law.	Covered as required by law.	Covered as required by law.

### MANDATED MEDICAL BENEFITS

Description of Medical Plan Coverage	Anthem Blue Cross/Blue Shield Plan		Premera Blue Cross/Blue Shield Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Mandated Maternity Benefits</b> The Plan shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours for normal or vaginal delivery or less than 96 hours for a cesarean section. However, the Plan does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan shall not require that a provider obtain authorization from the Plan of prescribing a length of stay not in excess of 48 (or 96 hours, if applicable).	Covered in full.	Covered as required by law.	Covered as required by law.	Covered as required by law.

### MEDICAL EXPENSES THAT ARE NOT COVERED

Description of Medical Plan Coverage	Anthem Blue Cross/Blue Shield Plan		Premera Blue Cross/Blue Shield Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Cosmetic Surgery – Elective</b> Charges for elective cosmetic surgery.	Not covered.	Not covered.	Not covered.	Not covered.
<b>Excess of Reasonable and Customary (R&amp;C)</b> For charges made which are in excess of R&C charges as determined by this Plan.	Participant not responsible for charges by in-network providers over and above the contracted allowable charges.	Not covered.	Participant not responsible for charges by in-network providers over and above the contracted allowable charges.	Not covered.

## MEDICAL EXPENSES THAT ARE NOT COVERED

Description of Medical Plan Coverage	Anthem Blue Cross/Blue Shield Plan		Premera Blue Cross/Blue Shield Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Experimental Procedures, Investigational or Unproven Treatment or Supplies</b> For services, treatment or supplies which are experimental, investigative, or unproven in nature.	Not covered.	Not covered.	Not covered.	Not covered.
<b>Felony/Illegal Occupation/Riot</b> Charges incurred as a result of a felony, illegal occupation or voluntary participation in a riot.	Not covered.	Not covered.	Not covered.	Not covered.
<b>Obesity Surgery</b> Charges for or in connection with surgery due to obesity.	Not covered.	Not covered.	Not covered.	Not covered.
<b>Provider Relationship</b> For services rendered by a person who is an immediate relative of or who ordinarily resides with the covered person requiring treatment.	Not covered.	Not covered.	Not covered.	Not covered.
<b>Sexual Dysfunction or Gender Reassignment</b> Charges for or in connection with sexual dysfunction. Charges for or in connection with sex change, transsexual surgery and/or treatments related to or leading to transsexual surgery.	Not covered.	Not covered.	Not covered.	Not covered.

## MEDICAL EXPENSES THAT ARE NOT COVERED

Description of Medical Plan Coverage	Anthem Blue Cross/Blue Shield Plan		Premera Blue Cross/Blue Shield Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Workers' Compensation, Government Hospital, Payments Prohibited by Law and Payments Not Required</b>  Charges for or in connection with a sickness or injury for which a person is entitled to benefits under Workers' Compensation or similar law. Charges for treatment in a hospital owned or operated by the U.S. Government, and for which no charge is made. Charges for which payment from the Plan is prohibited by any law applicable to the person at the time the charges are incurred. Charges, which the person is not legally required to pay, or which would not have been made if no insurance existed.	Not covered.	Not covered.	Not covered.	Not covered.

11/2006

Open Enrollment for Benefits Effective January 1, 2007